A TEXT-BOOK OF
CHIROPRACTIC TECHNIQUE

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PATHOLOGY of Intervertebral SUBLUXATION

Structure - From Osteopathic research published in 1910 and later.

Gross

1. malposed vertebra
2. hypertonicity of intrinsic muscles
3. wedging of I.V. disc
4. shortening of ligaments and muscles (contractures)
5. stretching of ligaments and muscles.

Microscopic

1. hyperemia and hemorrhage by diapedisis in cord (mostly gray horns)
2. " " " in ganglia (symp. & DNRG)
3. primary nerve degeneration (including parts of the myelin sheath)
4. hyperplasia and metaplasia of endothelium and ligaments.

Function - From Chiropractic research

Segmental

Local
1. Nociceptive & proprioceptive disruptions of the Local Sensorial Conversational Tone which causes:
2. Altered segmental function leading to:
3. Vasodilation and hemorrhage by diapedisis,
4. Lowered pH and malnutrition,
5. Impaired active vasodilation leaving a cool strip.

Peripheral
1. Impaired active vasodilation leaving constriction and a cool strip.
2. Altered chronaxie with "detuning" of sensory input which results in
3. Perversion of normal reflexes which causes
4. Incoordination, sensory and trophic changes, paralysis.

Intrasegmental.
1. Reflex subluxations along direct neural pathways of multiple innervation.
2. Related subluxations in neurologically or mechanically unstable areas which may initiate further neuropathies with all the local and peripheral abnormalities listed above.

SYMPTOMS and SIGNS of Intervertebral SUBLUXATION

Objective (perceptable to the observer)

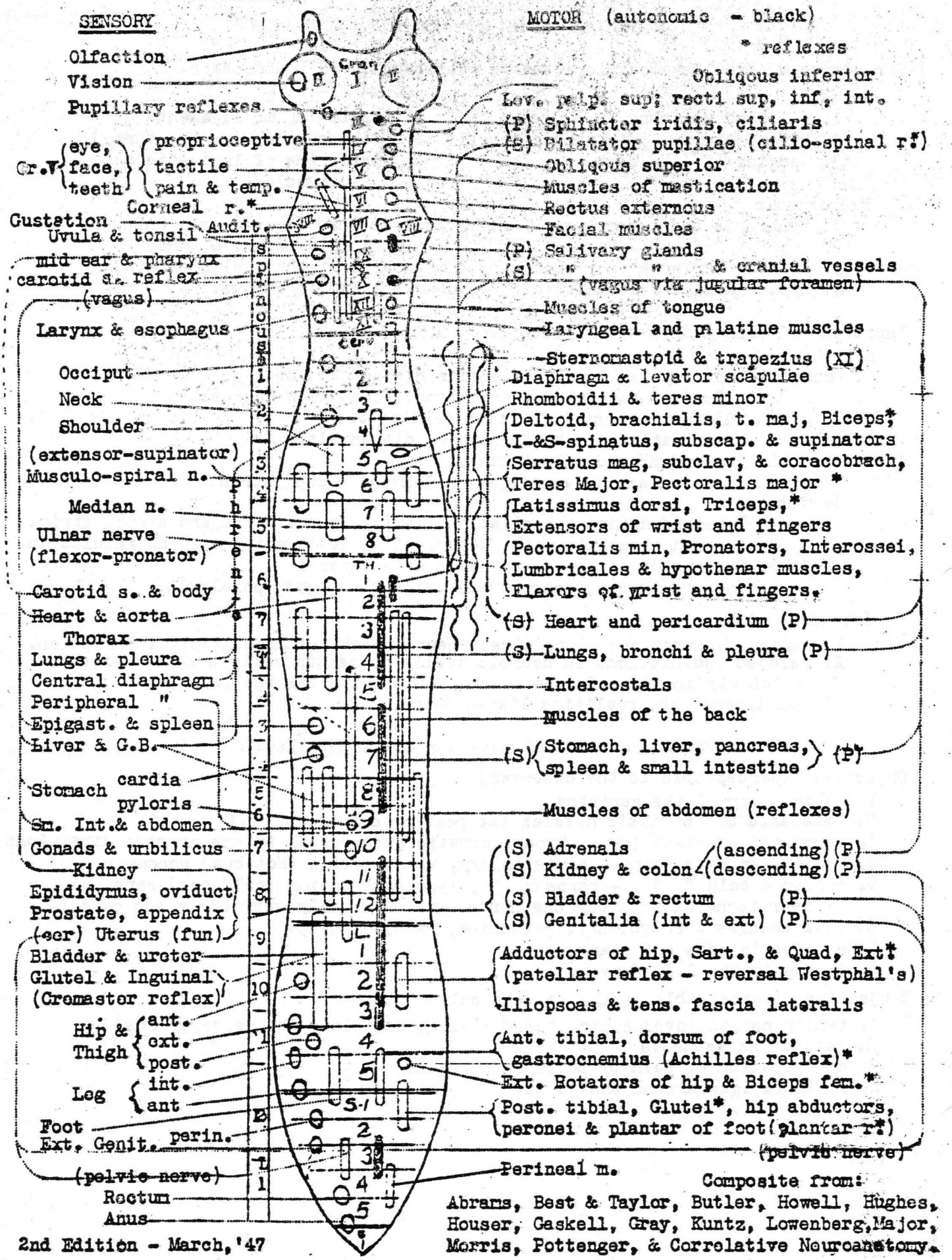
1. malposition of the vertebra
2. imbalance of intrinsic muscles (at rest or during motion)
3. perverted movement (hypo, hyper, erratic or reversal in one or more directions)
4. red & warm over joint - acute injury, vasodilation (Hot box) uncommon
5. pallor & cold " " - chronic " , vasoconstriction (cold box) rare (lower temperature along the nerve path is usually very early and common)
6. skin changes - rough, dry, petechiae, macules, etc.
7. changes in gait and stance.
8. Breaks in the A.P. Curves.

Subjective (perceptible to the patient only)

1. tender points (over contractured muscles and along the nerve tracts)
2. pain or paresthesia (" " " " ")
3. modification of pain by postural changes.
4. rapid fatigue around the joint.

SEGMENTATION and INNERVATION

by R.J.Watkins, D.C., Ph.C.



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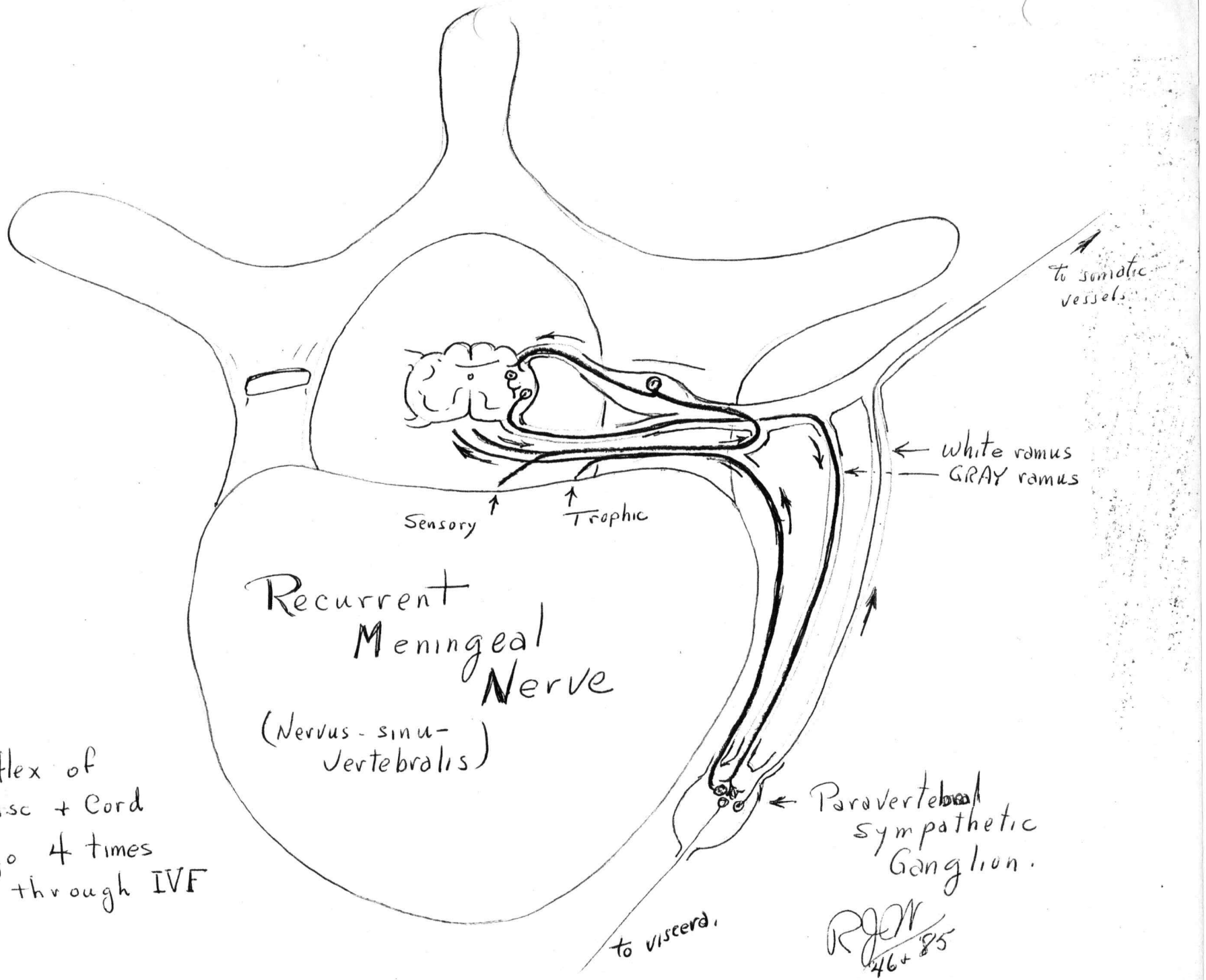

Reflex of Disc + Cord go 4 times through IVF

RJW 46+ '85

PROOF and ACCEPTANCE
of Chiropractic

R. J. Watkins, D.C.

October, 1985

Chiropractic science is based upon understanding body function and adaptability. Any adaptability (from hunger or burning heat) requires sensors, information collection, appropriate decision and coordinated action. All these areas have been recognized and proved in many ways by Hippocrates, Galen, Galvani, Sherrington, Pavlov and Uktumski long ago. The pathogenic effect of perverted spinal mechanics recorded by Hippocrates has been recorded by McConnell, Burns and Denslow in osteopathic research. Clinical results have been tabulated in all chiropractic schools since D.D. Palmer's original writings. Goldthwaite and Hadley stressed this neural pathogenesis. Suh and Luttges have verified much of this recently in Boulder, Colorado.

Now we hear "There has been no acceptable research." And "We need only to PROVE to the scientific community HOW chiropractic art is effective in treating disease and then we shall be accepted." One chiropractic researcher was discussing this in the mid 1960s with the head of the medical division of HEW in Washington, D.C. We were told that we would be requested to prove just one more point, then another and another until we have infallible, unquestionable proof that the greatest skeptic cannot deny. Then the entire method, theory and proof AUTOMATICALLY becomes a part of medicine and we, the small minority are then forced to become third rate M.D.s (D.O. is 2nd) or be prosecuted for illegally "practicing medicine".

Let us regain a realistic perspective. Even documented lab reports have been denied. The father of a D.C. in Toronto had chest X-rays plus 8 days of aspiration biopsies reporting grade IV bronchogenic carcinoma. One lung was completey opaque and the other had three tennis ball size opacities. The next day five minutes of palpation and adjusting cleared 95% of the spinal subluxations but a skin temperature variant persisted. After four HOURS of checking and rechecking with postural reflex technic the skin temperature balanced very well and the patient felt a deep calm and a "good feeling". This was maintained for four weeks with minimal adjusting. New X-rays showed one lung completely clear and the other with one small lesion. Aspiration biopsy showed only a few mitotic figures. The family was too elated to ask for copies of the films and lab reports then. Four weeks later the D.C. asked for copies of these reports. "What cancer ? That was a technicians error." was the reply. Even the surgeon who discussed the lung resection with the D.C. and his mother denied that there could have been any cancer.

Thus if we collect a thousand such "impossible" recoveries with undeniable "proof" it will be either delayed longer for "more proof" OR it is the practice of medicine. Do you want to be a third rate M.D. specializing in chiropractic by doing "manipulation" on medical prescription ? Or would you prefer prosecution for the practice of medicine.

Adolph Hitler clearly wrote his objectives in his book Mein Kampf. Karl Marx wrote Das Kapitol and clearly stated both his objectives and methods. Readers said "That is exaggeration, they can't possibly mean that." In 1948 Dr. Noble was president of the Academy of Medicine in

Toronto. His son, an attorney proposed three methods of eliminating the chiropractic profession in a confidential "Noble Report". The third method was "Elevate them to their own destruction". Pre-chiropractic was then High School or Ontario grade XIII, equivalent to U.S. first year university. Soon it was two years of college. Now it includes biology, inorganic and organic chemistry, physics, psychology, etc. Pressure is on to make it B.Sc., biochem. After that is no longer disputed then the next and last pre-requisite is an M.D. degree before studying chiropractic. The Hanneman College of Homeopathy likewise became an allopathic medical school. The chair of homeopathy persisted but was vacant at Hanneman for 50 years. Irvine medical college was an osteopathic school. To become acceptable to the AMA they only had to abandon their traditions on the osteopathic lesion. Some chiropractic schools had already denied subluxations and had "manipulable lesions" until Medicare (US federal health insurance) agreed to pay chiropractors for "manual manipulaltion of the spine" for the "subluxation demonstrated on (recent) X-rays" (but they will not pay for the X-rays). The various chiropractic colleges then met in Houston in 1972. They ignored the 1966 definitions and classifications of subluxations published by the ACA Council on Roentgenology. Instead they endorsed the old National College of Chiropractic classifications plus another on aberrant motion without describing the various types of dyskinesias.

Can we not recognize the trap and the bait? (1,2) Can we not recheck our own vast bank of terminology and clinical research data? The ultimate decision is NOT in AMA endorsement, is NOT in biased courts of law but is in the decision of patients with their good clinical results. Does the Ferrari dealer ask for Cadillac endoresement ? Does Boeing hire railroad engineers to design airframes ? Let us be fair to the patients and to our pioneers who built the profession entirely upon good clinical results with patients who were "medical failures". It was done by good palpation and good adjusting. The M.D.s trying to steal chiropractic and some chiropractors yearning to practice medicine remind me of two cows grazing over the barbed wire fence into opposing fields. Why is there an association of medical manipulators and the rash of texts on manipulation for the physiotherapists ? Think about it for a while.

Proof is and should be for the chiropractors and for the patients. Acceptance we seek should be that of our satisfied patients, not of hostile "competitors" with already published objectives to eliminate chiropractic.

1. The Ingenious Trap, Chiropractic Economics, October, 1968
2. Diagnosis - Boomerang ?, Todays Chiropractic, May, 1973

The Need to Graduate our Thinking...

"THE LITTLE BONE – OUT OF PLACE"

By Dr. R. J. Watkins, 60 Somerdale Square
Scarboro, Ontario, Canada

DR. R.J. WATKINS

Records of spinal manipulation date from ancient times in many civilizations. Bonesetters, Napravits, barbers in some oriental countries and many others have practiced various forms of manipulation. Obviously some benefits were derived by the patients, customers or clients or the practice would not have persisted.

The present connotation of "spinal manipulation" in medical literature implies a full excursion of a joint to tear out adhesions. A similar "mobilization" is the basis of many techniques used by many chiropractors and taught in some of the chiropractic colleges. Some were borrowed from the osteopaths. The "million dollar roll" was described by an osteopath and later "refined" as a "genu-deltoid hold." The vigorous contra-rotation and lumbar torque can tear a weakened annulus still further. Even so this technic is described by Christopher, Mennell, Burke, Maitland, Cyriax and other medical manipulators as useful in lumbar "disc syndrome."

The Palmer writings and the X-ray interpretations from static, neutral position films as done for years in most chiropractic colleges certainly did encourage the concept of "the little bone—out of place." The dynamic thrust," the "cumulative effect" and the "holding power" of adjustments all suggest tedious realignment of a stack of slippery bricks. In many chronic subluxations maintained by contractures (not contractions), which imply intramuscular fibrosis and adhesion shrinkage, these concepts are quite valid and the old technics are still generally useful.

Next came the "fixation concept" in which there could be limited motion in one, several or all directions. Part of these were and are valid concepts. These problems do, at times, respond well to mobilization. Here is the major field in which Henri Gillet and others have done much pioneering. The rehabilitation, most dramatic in scoliosis correction, by graduated exercises was a major contribution of Fred Illi. Precise corrective exercises to strengthen the lumbopelvic area was a pioneering contribution of L.J. Steinbach. Exercises could be used more widely and effectively in weak areas.

The disc herniation fits into none of the proceeding concepts although it is a collapse of a chronically weakened disc, similar to a pathological fracture of a vertebrae body in a geriatric patient. The weakening does result from a local, acute subluxation (a bone out of place) which has usually subsided and persists as a minor irritant. This is often from a "near-ideal" position geometrically. The chronic subluxation with minimal "displacement" but with intrinsic muscle imbalance must be adjusted in some manner to allow healing to occur. Yet the faulty disc is literally torn and should not be aggravated. A "lumbar roll" can tear such a disc still more.

Postural reflex technic (1) for correction is ideal in such disc conditions. With such an adjustment properly done, there is no "dynamic thrust," no "concussion of forces" and no aggravation either of the tear or of the neurological perversion. Yet this can be extremely precise adjusting with prompt muscle rebalance, immediate relief of symptoms, allowing resumption of normal neurophysiology with the rapid healing effect and with excellent long term results. These technics are predictable, repeatable and rapidly accomplished. As such they are truly chiropractic adjustments, done by hand, re-establishing vertebral alignment with normalized kinesiology, normalized skin temperature and reversal of associated pathology. The Logan College probably has done the most to put light contacts into consistently proven use. No more pressure than you can comfortably bear against your own eye through the lid, is the optimum.

Lest we become conceited and say or think that we cured a disease or treated a pathology let us recall an example of physiological response. S.J. Burich once posed a question in court replying to data on the force needed to move a vertebra in a hog's spine. "How many gallons of castor oil does it take to move the bowels of a cadaver?" Literally no doctor ever cured anything. A chiropractor can only remove roadblocks, re-tune the sensory input response. This subluxation, the "roadblock" by de-tuning the sensory input was interfering with normal physiology and recovery. The healing is from the Intelligent, living force within the body. The iodine and the bandaid don't heal a cut any more than they do if placed on a cut made in a piece of fresh steak. The healing is the physiological response of the living body.

Several other approaches to rebalancing spinal musculature have developed. Some are more dramatic than others but all are effective when used as intended. Some use "trigger spots." Some use acupuncture points with chemical, electrical or mechanical stimulus. Some use "zone therapy." None of these are effective when used improperly.

The recent description of "reversal" subluxations (2) has demonstrated a new dimension in dyskinesias never before described. Strangely, these are usually residual from local, direct trauma but are perpetuated by a segmental neuropathy initiated elsewhere. A careful study of multiple sensory and motor innervation should help to understand and to predict results. Examples, such as the headache from an Occ-C1 subluxation clearing quickly by adjusting L5; the sciatica clearing after a T12 adjustment and the elbow pain leaving promptly after a T7 adjustment, all become neurologically understandable.

The "snow job" explanation, the vague, etherial philosophizing (It is God's will) are usually valid and correct but not really acceptable explanations to a neurophysiologist who likes to know slightly more about "How Innate works."

The word "adjustment" easily and logically includes the delicate rebalancing of intrinsic muscles which relieve the dyskinesia and the segmental symptoms even when introduced by a very light contact many inches away from the symptom-producing segment. The word "manipulation" cannot be so construed without adding a colloquial meaning far different from the usual connotation.

Adjusting the windage compensation on an artillery sighting device, adjusting a carburetor, adjusting the headlights, adjusting brake balance, adjusting binocular collimation, adjusting trimmer condensors, adjusting ones eyeglasses, all convey a meaning to nearly everyone alike of a delicate, controlled action; a precise, precalculated accomplishment, done by a skilled, well trained, confident individual.

Manipulation as a generic term includes more gross actions; tying one's shoelaces, dragging rocks into place in a pool, tinkering with old assembly parts, throwing a belt off a big engine, roughly lining up a tractor-trailer to a loading dock, berthing a ferry boat, hooking a chain on a log or setting a dynamite charge to blow a log jam. The word "manipulation" is seldom used to imply any delicate, precise action like adjusting the grinding angle of a diamond facet. Medical manipulation is usually described as a gross, vigorous action, occasionally as "taxing even a strong man." Thus it is well to consider carefully the more common definitions of words. Few persons at this time "sod pottage" but they do "simmer the stew." It may taste the same but could cause someone to decline tasting an excellent meal.

One lady asked a chiropractor, "Are you a 'Rub-Em' or a 'Punch-Em'?" He pleaded innocence so she said "Oh, you know, an osteopath rubs 'em and a chiropractor punches 'em, which are you?" We still occasionally hear "I want you to crack my neck;" "Don't give me that rabbit punch, it hurts;" "I need a rub down;" "Will you pop my hip?" Such remarks have been crudely descriptive but are hardly appropriate. If not corrected at every opportunity, we are being derelict in our professional duty of passing on correct public information.

Such gross manipulations as these, are often useful and are commonly used in many offices. However there are finer, more precise and more delicate methods of adjusting subluxations. Pounding down the "high spots" and "spine straightening" often can and do cause more trouble than they correct. Precise postural reflex technics whether of perianal (1) or auricular origin, (3) are basically proprioceptive. They cannot traumatize a precarious pathology, whether fracture, carcinoma or simple subluxation. Therefore let us not perpetuate myths that we are "bone crackers." That thought scares away many who would find their best relief in a chiropractic office. There are gentler and more precise methods available which are very effective and not overly time consuming.

This is not to imply that long apologies are needed. One preschool lad asked his dad "Where did I come from?" After a tedious lecture on reproduction and genetics the lad said, "Thanks, Dad, but Bill says he came from Edmonton." Each patient wants questions answered. We must first understand the question.

Increasing thumb pressure on the ulnar nerve dramatically illustrated that "going to sleep" is neurological and not vascular. A comparison of a stomach half asleep can explain slow, gassy digestion while the irritable, hyperactive stomach digesting itself illustrates ulcers. After "feeling" the tense and touchy rotatore of T7 and the hypersensitive, hypertonic suboccipital oblique muscles the patient can relate the "punch in the back" to his request to "fix his stomach." The relationship is still more obvious when the patient feels the muscle spasms subside and the tenderness disappear within seconds during a proper, light perianal contact. He is convinced when the stomach pain does not return.

This discussion is to exemplify the great need to graduate our own thinking and to progress far above the "little bone out of place" and the "stepping on the hose" concept. These simple analogies are very useful in helping the understanding of many laymen. Unfortunately, these simple concepts have been used very often as though they were the only answers when a much deeper understanding was expected.

1. Perianal Postural Reflex Technic—European Chiropractic Union Bulletin—current issue.
2. Subluxation Terminology Since 1746—Journal A.C.A.—Sept. 1968.
3. Auricular Proprioceptive Reflex Technic—Chiropractic Economics—Oct. 1966.

Subsequent articles clarify and add to this concept.

Neurological First Aid Kit	Chiro Econ	June	'70
Diagnosis - Boomerang	Today's Chiro.	May	73
Reversal Subluxation	Chiro Econ.	Aug.	74
Monitoring Sub. Interrelationships	"	Oct	74
The Great Ventriloquist	Chiro.Econ.	Feb	75
All-or-None	Chiro Econ	Apr	75
Perianal Postural Refl Tech	" "	June	75
Finger Walk	Todays Chiro	May	75
Unilateral Reversal Sublux	Chiro Ecn	Sept	80
Gout	Chiro Econ	Feb	81
Side Effects	Chiro Econ	Feb	82

We can save much confusion and misunderstanding by careful use of semantics. By clearly defining terms most arguments are avoided. So perhaps we can re-evaluate our definitions in the light of common usage. I rarely manipulate but I do adjust spinal columns as lightly and as precisely as I can possibly manage. RJW - April, '82